MARKET CONDUCT EXAMINATION

STANDARD INSURANCE COMPANY

1100 SW 6TH AVENUE
PORTLAND, OR 97207-0711

January 1, 2000 – September 30, 2001

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August 29, 2002

The Honorable Mike Kreidler
Washington State Insurance Commissioner
Insurance Building
P.O. Box 40255
Olympia, Washington 98504

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.03.010 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed of:

Standard Insurance Company, NAIC #69019
1100 SW 6th Avenue
Portland, OR 97207-0711

This report of examination is respectfully submitted.

This was a target examination of the companies' activities in group long term disability insurance between January 1, 2000 and September 30, 2001.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Nancy L. Barnes, AIE, ACS, George J. Lazur, AIE, CPCU, and Heather O. Budd of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of Standard Insurance Company during the course of this market conduct examination.

I certify that the following is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner, and that this report is true and correct to the best of my knowledge and belief.

_____

Leslie A. Krier, AIE, FLMI
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

This market conduct examination report is by exception and additional practices, procedures, and files subject to review during the examination were omitted from the report if no improprieties were indicated. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

Scope

Time Frame

The examination covered the company's operations from January 1, 2000 through September 30, 2001. This was the first market conduct examination of Standard Insurance Company by the Washington OIC and was performed both in the Seattle office and on-site at the company's home office in Portland, Oregon.

Matters Examined

The examination included a review of the following areas:

Complaints
Underwriting
Claims

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance.

These are the guidelines prescribed by the National Association of Insurance Commissioners in the Market Conduct Examiners Handbook.

Regulatory Standards

Samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as "met." The standard in the area of agent licensing and appointment will not be met if any

violation is identified. The standard in the area of filed rates and forms will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

COMPANY OPERATIONS AND MANAGEMENT

Standard Insurance Company ("Standard" or "Company") was incorporated on February 24, 1906 and commenced operations on April 12, 1906. The Company is domiciled in the State of Oregon. Standard was originally incorporated as Oregon Life Insurance Company. In 1929 the Company was mutualized at which time the name was changed to Oregon Mutual Life Insurance Company. In 1946 the present name was adopted. In April of 1999, the Company demutualized and became a subsidiary of StanCorp Financial Group, Inc.

Standard Insurance Company was admitted to do business in the State of Washington April 12, 1921. The Company offers a wide range of group and individual life, annuity, and disability insurance products. Its major focus is in the group long term disability and group life insurance markets. As of the examination date, 99 percent of the Company's operations in the State of Washington were in the group insurance market.

The Company is governed by StanCorp Financial Group, Inc.'s 13 member Board of Directors. The board members as of December 3, 2001 are:

Virginia Lynn Anderson
John Edgar Chapoton
Richard Geary
Peter Ogden Kohler, M.D.
Ester Kay Stepp
Michael G. Thorne
Franklin Edgar Ulf III
Frederick William Buckman
Barry Jack Galt
Peter Thomas Johnson
Jerome Jergen Meyer
William Swindells
Ronald E. Timpe

Findings

The Company met the following Company Operations and Management Standards without comment:

Standard	Reference
<u>Company Operations and Management Standard #1:</u> The Company must facilitate the examination process by providing its accounts, records, documents, and files to the examiners upon request.	**RCW 48.03.030(1)**
<u>Company Operations and Management Standard #2:</u> The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a disability insurance carrier in the State of Washington.	**RCW 48.05.030(1)**
<u>Company Operations and Management Standard #3:</u> The Company must maintain adequate, accessible, consistent, and orderly accounts and records.	**RCW 48.05.280**

COMPLAINTS

Procedures

Standard provided a copy of its complaint procedures to the examiners. The procedures consist of a one-page document that outlines the processes for the handling of both direct customer complaints and complaints that are received from insurance departments.

If a complaint is received directly from a consumer, the procedures are as follows:

- Date stamp including the receiving department and area.
- A same-day response is to be sent to the consumer notifying that the complaint has been received and that investigation of the complaint will ensue.
- The complaints are to be entered into a log.
- A complete response is sent to the consumer within three (3) working days. If further investigation is required, written follow up is done every 14 calendar days.
- Upon completion of the complaint, a complaint record form is completed and signed by the responding person, manager/department head, and a division head if the complaint concerns an individual plan or a retirement plan.
- After all signatures are obtained, the complaint file is sent to the Public Affairs Department and the complaint is officially closed.

If a complaint is received from the OIC, the procedures are as follows:

- Date stamp including the receiving department and area.
- A letter is sent to the OIC the same day the complaint is received. This letter acknowledges receipt and notes that the Company will be investigating the complaint and responding to the issues raised.
- A copy of the acknowledgement letter is sent to the Public Affairs Department for tracking.
- Within three (3) working days, the procedures state that the complaint will be responded to in full. If further investigation is required, follow up letters are sent to the OIC every 14 calendar days.
- All information and attachments requested by the OIC are forwarded with the response.
- A copy of each response is forwarded to the Public Affairs Department for tracking.
- Upon completion of the complaint, the complaint record form is completed and signed by the responding person, manager/department head, and division head.
- After all signatures are obtained, the complaint file is sent to the Public Affairs Department and the complaint is officially closed.

The Company begins tracking complaints when a customer or regulator submits a formal grievance. The Company defines a complaint as an expression or grievance requiring action from an authority above the person who would normally handle the matter. It tracks only those

items that meet this definition. The examiners were provided with a database of 81 complaints received during the examination period. One (1) file was a duplicate listing, and only eight (8) files were direct consumer complaints, leaving 72 files that were OIC generated complaints. This figure is in agreement with records maintained by the OIC. Open claim file complaints, with the exception of OIC complaints, are handled as part of claim adjudication.

Complaint File Review

There were 81 complaints in the database provided to the examiners. A random sample of 50 files was selected based on NAIC Market Conduct Examiner Handbook guidelines and ACL Audit Software. Ten (10) files were removed from the sample because they fell outside the scope of the examination.

The examiners reviewed the remaining 40 files. Two (2) of the files in the sample were direct consumer complaints and the remaining 38 files were OIC complaints. The files were tested to assure compliance with timely and adequate response.

The complaints reviewed can be broken down into two (2) categories:

Type of Complaint	Number
Underwriting	2
Claims Handling	38

Findings

The following exceptions were noted:

Standard	Reference
<u>Complaint Standard #1:</u> Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC.	**WAC 284-30-360(2), WAC 284-30-650, Technical Advisory T 98-4**

Findings: Failed. 94.7% compliance.

The examiners reviewed 38 complaint files that the Company received from the OIC. An acknowledgement letter from the Company is forwarded to the OIC. Within three (3) days of receipt and following the acknowledgement letter, Company personnel forward a full response, or state the reasons that a full response cannot be given, to the OIC. Two (2) of the 38 files reviewed exceeded the 15 working day requirement.

The violations are listed in Appendix I.

UNDERWRITING

Underwriting Manuals

Standard provided the examiners with two (2) underwriting manuals – the Group Underwriting Manual and the Disability Income Underwriting Manual. The manuals are intended to be used by Company underwriting personnel and by agents in the field. The examiners reviewed the manuals to determine if the underwriting guidelines were reasonable and consistent. They were found to be complete and clearly state the medical and financial information needed to process new applications for both group and individual coverage.

Underwriting Process

Approximately 99% of all business generated in the State of Washington is group insurance. However, individual supplemental coverage may be offered within a group plan creating the need for individual underwriting considerations.

Proposals for coverage are issued to interested groups based on preliminary risk evaluations and census data that are gathered either by company personnel or agents and brokers soliciting coverage on behalf of the Company. If a group accepts a proposal, an application for group insurance is submitted to the Company along with first month's premium payment. Once approved, the completed application becomes the source of information for creating the policy.

Contract renewals are determined based on the rate guarantee stated in the contract at the time of sale. The rate guarantee is typically for a period of one (1), two (2), or three (3) years. Every contract is reviewed approximately ninety (90) days prior to the expiration of the rate guarantee period to ensure that the current rate being charged is adequate for the assumed risk. During the renewal process, the following factors are considered:

- Group demographics (size, age composition, salary composition, growth, contribution levels, industry classification)
- Company underwriting guidelines and factors (contribution levels, minimum premium requirements)
- Claims experience on groups of 250+ lives
- Financial stability of the group
- Industry strength
- Benefit utilization

Evidence of insurability (individual underwriting) is a requirement for late enrollees. It is also used when an employer offers supplemental "buy-up" coverage beyond the guarantee issue amounts available in the basic group contract.

Group Contract Underwriting File Review

The examiners asked Standard to provide them with population figures for the examination period. Databases with the following information were provided:

- 8,053 in force group disability contracts
- 227 terminated group disability contracts
- 403 declined individual applications

The examiners selected the following samples from the above databases using NAIC market Conduct Examiner Handbook guidelines and ACL Audit Software:

- 64 group disability contracts (44 in force and 20 terminated contracts)
- 40 declined individual applications

From the total of 64 group disability contracts requested, 54 files were reviewed. Of the 44 in force group disability contracts selected, ten (10) of the files were removed from the sample due to the following reasons:

- Two (2) contracts were written in the State of Oregon.
- Four (4) contracts were administrative services only (ASO) contract files.
- Three (3) contracts were terminated prior to the beginning of the examination period.
- One (1) contract was written in the State of California.

Findings

The Company passed the following Group Long Term Disability Underwriting Standards without comment:

Standard	Reference
Group Underwriting Standard #3: All policies must be delivered to the insured within a reasonable period of time after its issuance.	**RCW 48.18.260**
Group Underwriting Standard #4: The Company may not use unfair discrimination between insureds having substantially like insuring, risk, and exposure factors, or expense factors.	**RCW 48.18.480**
Group Underwriting Standard #5: The Company must send a declination notice to the insured and the agent with the reason for denial	**RCW 48.18.540**
Group Underwriting Standard #6: No insurer or agent may offer a rebate to insured as inducement to purchase the insurance policy.	**RCW 48.30.140**

Standard	Reference
Group Underwriting Standard #7: No policy is refused issue, cancelled, or non-renewed on the basis of unfair discrimination.	**RCW 48.30.300(1)**
Group Underwriting Standard #8: Receipt must be given to the insured by the agent for money collected with application.	**WAC 284-30-550**
Group Underwriting Standard #9: The declination notice must include the reason for the denial of coverage.	**WAC 284-30-570**
Group Underwriting Standard #10: Insurer must make an independent evaluation to support any cancellation, denial, or nonrenewal.	**WAC 284-30-574**

The Company passed the following Group Long Term Disability Standard with comment:

Standard	Reference
Group Underwriting Standard #1: All policies must use a written application completed by the applicant.	**RCW 48.18.060**

Findings: Passed with comment. 96.3% compliance.

There was one (1) application and one (1) amendment in the sample that were not signed by representatives of the group contract holder. See Appendix III.

The following exceptions were noted:

Standard	Reference
Group Underwriting Standard #2: No alterations may be made to the application except by the applicant.	**RCW 48.18.070**

Findings: Failed. 85.2% compliance.

There were eight (8) applications that contained white out and/or stricken information. These changes to the applications were not initialed by the applicants or the Company. See Appendix IV.

Subsequent Event: On June 20, 2002, the Company's Vice President of Regional Operations communicated to sales and underwriting staff by email that it is against policy to use whiteout or to otherwise alter a formal application unless initialed by the applicant.

Individual Underwriting File Review

As described above, the examiners reviewed 40 declined individual underwriting files from the population of 403 files. Many of the groups reviewed above offered their employees the opportunity to purchase enhanced coverage on a contributory basis. The enhanced coverage

included, but was not limited to, shorter benefit waiting periods or higher replacement of income.

Findings

The Company passed the following Individual Underwriting Standards without comment:

Standard	Reference
Individual Underwriting Standard #1: All policies must use a written application completed by the applicant.	**RCW 48.18.060**
Individual Underwriting Standard #2: No alterations may be made to the application except by the applicant.	**RCW 48.18.070**
Individual Underwriting Standard #3: All policies must be delivered to the insured within a reasonable period of time.	**RCW 48.18.260**
Individual Underwriting Standard #4: The Company may not use unfair discrimination between insureds having substantially like insuring, risk, and exposure factors, or expense factors.	**RCW 48.18.480**
Individual Underwriting Standard #5: The Company must send a declination notice to the insured and to the agent with the reason for the denial of coverage.	**RCW 48.18.540**
Individual Underwriting Standard #6: No insurer or agent may offer a rebate to the insured as inducement to purchase the insurance policy.	**RCW 48.30.140**
Individual Underwriting Standard #7: No policy is refused issue, cancelled, or non-renewed on the basis of unfair discrimination.	**RCW 48.30.300(1)**
Individual Underwriting Standard #8: Receipt must be given to the insured by the agent for money collected with the application.	**WAC 284-30-550**
Individual Underwriting Standard #9: Company must provide the actual reason for canceling, denying, or refusing to renew insurance to the applicant or insured.	**WAC 284-30-570**
Individual Underwriting Standard #10: Insurer must make an independent evaluation to support any cancellation, denial, or nonrenewal.	**WAC 284-30-574**
Individual Underwriting Standard #11: All applications must include a question regarding replacement of any other disability insurance, or use a supplemental application or other form signed by the applicant.	**WAC 284-50-430(1)**
Individual Underwriting Standard #12: If replacement of another policy is involved, the Company must furnish the required replacement notice to the applicant to be signed before issuance of the new policy.	**WAC 284-50-430(2)**
Individual Underwriting Standard #13: All replacement notices must comply with the specified form.	**WAC 284-50-430(3)**

The examiners found that three (3) applications for supplemental coverage were not thoroughly underwritten due to procedural errors. As prescribed in the Company's underwriting manual, health questionnaires and/or Attending Physician Statements were to be requested and were not.

- One (1) application was denied based on health information on the application. The Company's procedures state that an Attending Physician's Statement is to be ordered for the condition in question, and it was not ordered by the underwriter. After questioning by the examiners, the Company stated that this decision was made in error. Company personnel stated that if the group was still active, the file would be reopened for additional underwriting.
- Two (2) applications were denied based on health information on the application. Both applications were for the same applicant. The Company did not follow its underwriting procedures and did not request an independent medical examination, Attending Physician's Statement, or additional health questionnaire as defined in its underwriting procedure manual. After questioning by the examiners, the Company stated that the underwriting decisions were made in error. The applicant was contacted by the Company, offered the opportunity to submit additional evidence of insurability, and was ultimately approved for coverage.

The examiners confirmed that the Company has audit procedures in place to monitor underwriting practices. Group underwriting is monitored on a monthly basis, with 15 to 20 percent of the cases reviewed by supervisors to assure correct underwriting decisions. Individual underwriting, with a focus on denied cases, is audited on a quarterly basis. Five (5) cases from each underwriter are reviewed for legal, medical, and quality decisions. In addition, the Company's internal audit department conducts annual risk assessments of key departments including both group and individual underwriting.

CLAIMS

Claim Processing Manual

The Company provided the examiners with a copy of the Group Benefits LTD Claims Manual that was in use during the examination period. The manual was reviewed and found to be very detailed. It outlines the policies and procedures of the Group Benefits Department and is designed to act as a guide for claims processing. It is complete and provides reasonable standards for the processing and payment of claims as required by WAC 284-30-330(16).

Claims Department Organization

Group long term disability claims are handled by the Company's Group Benefits Department. The department is organized into Long Term Disability Teams. The teams consist of a Supervisor, Senior Disability Benefits Analysts, Associate Disability Benefits Analysts, and Disability Benefits Processors. The Company also has a Claims Management Resources Unit.

Members of this unit include a Supervisor, Medical Specialists, Vocational Rehabilitation Specialists, Resources Administrative Coordinators, and Benefits Tax Specialists. This unit provides support and additional resources to the Long Term Disability Claims Teams.

Claim activities and decisions are reviewed and authorized within each team and/or unit. This includes review of activities such as claim decisions, application of policy limits and exclusions, benefits payments, overpayment calculations, claim management plans, and service requests.

Individual long term disability claims are processed by the Company's Individual Benefits Department. The processes for claim handling are identical to those used by the Group Benefits Department.

Claims Processing

When the Company is notified of a potential long term disability claim, a packet is provided to the claimant. Each packet includes an Employee's Statement, Employer's Statement, Attending Physician's Statement, and an Authorization to Obtain Information. Completed forms returned to Standard are date stamped, a new claim file is created, and the file is assigned to a Disability Benefits Analyst.

The Disability Benefits Analyst reviews the group policy, comparing the proof of loss information with the benefits available to the claimant at the time of disability. The analyst confirms the definition of disability and confirms that the condition is disabling. The analyst also determines the length of time that benefits are payable, the benefit amount, and whether any other offsetting benefits are available to the claimant.

If the information provided is sufficient to determine a claimant's disability, a letter is prepared to advise of the decision. In many cases, however, it is necessary to obtain more detailed medical information or more information from the claimant's employer in order to make a decision. A letter is sent to the claimant advising that further information is needed to make a decision. Follow up letters are sent as required.

After all of the requested information is received, it is reviewed by the analyst and referred for approval to a higher level of authority or to the medical specialist for review. After a determination has been made, the claimant is notified of the decision both by telephone and in writing. If the claim has been approved, a check is processed and is sent at the same time.

Internal Claims Auditing

The Company conducts internal audits of open and closed claims on a monthly basis. The audits are conducted by claims supervisors and Quality Assurance Specialists. The audits are based on written performance expectations using several different audit forms that lead the reviewer through the established auditing procedure. The examiners were provided with copies

of the auditing forms. The forms include over 40 performance requirements specific to claims handling and processing.

Claims Review

The Company database provided to the examiners included a total population of 9,045 claims during the examination period. Within this population, there were 8,053 claims that were open and 992 claims that were denied. It should be noted that the open claims included many that have been open for a number of years, not just the claims that were initiated during the examination period.

Using NAIC Market Conduct Examiners Handbook guidelines and ACL Audit Software, a sample of 100 open claims and 30 denied claims was drawn from this population. Two (2) claims included in the sample were outside the scope of the examination. Both of these claims were for Administrative Services Only (ASO) contracts.

Final action on the 128 claims reviewed is as follows:

Action	Number	Percentage
Open – Payments still being made to claimant	48	37.5%
Closed with Payment – Returned to work	30	23.4%
Closed with Payment – Claimant died	5	3.9%
Closed with Payment – Benefit period exhausted	14	10.9%
Closed with Payment – Claimant uncooperative and was found working while collecting benefits	1	0.8%
Denied – No proof of loss submitted	11	8.6%
Denied – Claimant recovered during benefit waiting period	7	5.5%
Denied – Claimant not disabled from own occupation	5	3.9%
Denied – Returned to work during benefit waiting period	3	2.4%
Denied – Pre-existing condition	4	3.1%
TOTAL	**128**	**100%**

Findings

The Company passed the following Claims Standards without comment:

Standard	Reference
Claims Standard #1: The Company shall not engage in unfair claims settlement practices.	**WAC 284-30-330(1) through (19)**
Claims Standard #2: The Company shall maintain complete claim files so that all aspects of the claim adjudication process can be reconstructed.	**WAC 284-30-340**

Standard	Reference
Claims Standard #3: The Company shall not misrepresent any policy provisions during the claim payment process.	**WAC 284-30-350(1) through (7)**
Claims Standard #4: The Company must acknowledge all pertinent communications promptly.	**WAC 284-30-360**
Claims Standard #5: The Company shall promptly investigate all claims.	**WAC 284-30-370**

The Company passed the following Claims Standard with comment:

Standard	Reference
Claims Standard #6: The Company shall promptly, fairly and equitably settle all claims.	**WAC 284-30-380(1) through (6)**

Findings: Passed with comment. 96.1% compliance.

The examiners found five (5) files in violation of WAC 284-30-380(1) that states that the Company shall pay or deny all claims within 15 working days after receipt of properly executed proofs of loss. In all five (5) claims, there were more than 15 working days that had passed between the receipt of the Attending Physician's Statement and the date that the decision to pay or deny the claim was communicated to the claimant. See Appendix V.

In January 2000, the Company hired a full-time medical director and added 11 additional physician consultants to staff to improve claims timeliness and to assure satisfaction of internal standards and procedures. In addition, between January 2000 and July 2000, a total of 50 claims processing positions were added.

INSTRUCTIONS

	INSTRUCTIONS	PAGE #
1	The Company is instructed to respond to all inquiries from the Office of Insurance Commissioner within 15 business days of receipt of the correspondence. All responses must contain the substantial information requested by the OIC. Reference: WAC 284-30-360(2), WAC 284-30-650, Technical Advisory T 98-4	9
2	The Company is instructed to cease the use of white out on applications. The Company is instructed to assure any alterations to an application are initialed and dated by the applicant and the Company. Reference: RCW 48.18.070	12

RECOMMENDATIONS

	RECOMMENDATIONS	PAGE #
1	It is recommended that the Company thoroughly review all applications and amendments to assure signatures are present. Reference: RCW 48.18.060	12
2	It is recommended that the Company pay or deny all claims within 15 working days after receipt of properly executed proofs of loss. Reference: WAC 284-30-380(1)	17

SUMMARY OF STANDARDS

Company Operations and Management:

#	STANDARD	PAGE	PASS	FAIL
1	The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.03.030(1)	7	X	
2	The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a disability insurance carrier in the State of Washington. Reference: RCW 48.05.030(1)	7	X	
3	The Company must maintain adequate, accessible, consistent, and orderly accounts and records. Reference: RCW 48.05.280	7	X	

Complaints:

#	STANDARD	PAGE	PASS	FAIL
1	Response to communications from the Office of Insurance Commissioner must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC. Reference: WAC 284-30-360(2), WAC 284-30-650, Technical Advisory T 98-4	9		X

Group Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	All policies must use a written application completed by the applicant. Reference: RCW 48.18.060	12	X	
2	No alterations may be made to the application except by the applicant. Reference: RCW 48.18.070	12		X
3	All policies must be delivered to the insured within a reasonable period of time after its issuance. Reference: RCW 48.18.260	11	X	
4	The Company may not use unfair discrimination between insureds having substantially like insuring, risk, and exposure factors, or expense factors. Reference: RCW 48.18.480	11	X	
5	The Company must send a declination notice to the insured and the agent with the reason for denial of coverage. Reference: RCW 48.18.540	11	X	
6	No insurer or agent may offer a rebate to the insured as an inducement to purchase the insurance policy. Reference: RCW 48.30.140	11	X	

#	STANDARD	PAGE	PASS	FAIL
7	No policy is refused issue, cancelled, or non-renewed on the basis of unfair discrimination. Reference: RCW 48.30.300(1)	12	X	
8	Receipt must be given to the insured by the agent for money collected with the application. Reference: WAC 284-30-550	12	X	
9	The declination notice must include the reason for the denial of coverage. Reference: WAC 284-30-570	12	X	
10	Insurer must make an independent evaluation to support any cancellation, denial, or nonrenewal. Reference: WAC 284-30-574	12	X	

Individual Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	All policies must use a written application completed by the applicant. Reference: RCW 48.18.060	13	X	
2	No alterations may be made to the application except by the applicant. Reference: RCW 48.18.070	13	X	
3	All policies must be delivered to the insured within a reasonable period of time after its issuance. Reference: RCW 48.18.260	13	X	
4	The Company may not use unfair discrimination between insureds having substantially like insuring, risk, and exposure factors, or expense factors. Reference: RCW 48.18.480	13	X	
5	The Company must send a declination notice to the insured and the agent with the reason for denial of coverage. Reference: RCW 48.18.540	13	X	
6	No insurer or agent may offer a rebate to the insured as an inducement to purchase the insurance policy. Reference: RCW 48.30.140	13	X	
7	No policy is refused issue, cancelled, or non-renewed on the basis of unfair discrimination. Reference: RCW 48.30.300(1)	13	X	
8	Receipt must be given to the insured by the agent for money collected with the application. Reference: WAC 284-30-550	13	X	
9	Company must provide the actual reason for canceling, denying, or refusing to renew insurance to the applicant or insured. Reference: WAC 284-30-570	13	X	
10	Insurer must make an independent evaluation to support any cancellation, denial, or nonrenewal. Reference: WAC 284-30-574	13	X	
11	All applications must include a question regarding replacement of any other disability insurance, or use a supplemental application or other form signed by the applicant. Reference: WAC 284-50-430(1)	13	X	

#	STANDARD	PAGE	PASS	FAIL
12	If replacement of another policy is involved, the Company must furnish the required replacement notice to the applicant to be signed before issuance of the new policy. Reference: WAC 284-50-430(2)	13	X	
13	All replacement notices must comply with the specified form. Reference: WAC 284-50-430(3)	13	X	

Claims:

#	STANDARD	PAGE	PASS	FAIL
1	The Company shall not engage in or demonstrate a frequency of using any unfair claims settlement practices. Reference: WAC 284-30-330	16	X	
2	The Company shall maintain complete claim files with all notes and papers. Reference: WAC 284-30-340	16	X	
3	The Company shall not misrepresent any policy provisions. Reference: WAC 284-30-350	17	X	
4	The Company must acknowledge all pertinent communications promptly. Reference: WAC 284-30-360	17	X	
5	The Company will comply with the standards for prompt investigation of all claims. Reference: WAC 284-30-370	17	X	
6	The Company will comply with the standards for prompt, fair and equitable settlement of all claims. Reference: WAC 284-30-380	17	X	

APPENDIX I

<u>Complaint Standard #1:</u> Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC. Reference: WAC 284-30-360(2), WAC 284-30-650, and Technical Advisory T 98-4.

OIC ID #	CLAIM #	POLICY #	RESPONSE OVER 15 DAYS
29	272388 & 272389	377661	41 days
39	964359 & 964360	377661	49 days

APPENDIX III

<u>Group Underwriting Standard #1:</u> All policies must use a written application completed by the applicant. Reference: RCW 48.16.060.

OIC ID #	GROUP #	COMMENTS
28	615391	Request for Amendment was not signed by the group.
41	491905	Application for Group Insurance not signed by the group.

APPENDIX IV

<u>Group Underwriting Standard #2:</u> No alterations may be made to the application except by the applicant. Reference: RCW 48.18.070.

OIC ID #	GROUP #	COMMENTS
3	603157	Hourly eligibility requirement was changed and was not initialed by applicant.
7	607532	1) Premium contribution information was altered with white out. 2) Other Insurance, #B was altered with white out.
8	600352	Waiting Period for Eligibility information altered with white out.
14	605772	Persons to Be Insured altered with white out.
22	601979	1) Persons to Be Insured altered with white out. 2) Changed were made in the General Information section and these changes were not initialed.
27	496716	Numerous areas of white out and altered information. None of the alterations are initialed.
38	498289	1) Hourly eligibility information and effective date were changed and not initialed. 2) Affiliate Information section contained white out.
41	491905	Alterations made in the Other section and these changes were not initialed.

APPENDIX V

<u>Claims Standard #6:</u> The Company will comply with the standards for prompt, fair and equitable settlement of all claims. Reference: WAC 284-30-380.

OIC ID #	CLAIM #	PROOF RECEIVED	DECISION TO CLAIMANT	BUSINESS DAYS
32	952802	10/17/00	11/20/00	22
73	282243	08/18/97	09/17/97	20
117	978445	08/20/01	09/17/01	18
118	981246	11/16/01	12/28/01	23
119	948997	06/05/00	08/03/00	41

Note: The above referenced claims are violations of WAC 284-30-380(1). WAC 284-30-380(1) states that the Company shall pay or deny all claims within 15 working days of receipt of properly executed proofs of loss.